MDR Tracking Number: M5-05-1030-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution - General and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division (Division) assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. The dispute was received on 12-01-04.

The Division has reviewed the enclosed IRO decision and determined that **the requestor did not prevail** on the majority of the medical necessity issues. Therefore, the requestor is not entitled to reimbursement of the IRO fee.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

The work hardening program from 12-1-03 through 12-3-03 **was found** to be medically necessary. The work hardening program and functional capacity exam from 12-4-03 through 1-16-03 **was not found** to be medically necessary. The respondent raised no other reasons for denying reimbursement for the above listed services. The amount due the requestor for the medical necessity issues is $1,216.00.

Based on review of the disputed issues within the request, the Medical Review Division has determined that medical necessity fees were the only fees involved in the medical dispute to be resolved. As the services listed above were not found to be medically necessary, reimbursement for dates of service 12-4-04 through 1-16-04 are denied and the Medical Review Division declines to issue an Order in this dispute.

On this basis, and pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the Respondent to pay the unpaid medical fees totaling $1,216.00 for 12-1-03 through 12-3-03 outlined above as follows:

- In accordance with Medicare program reimbursement methodologies for dates of service on or after August 1, 2003 per Commission Rule 134.202 (c);
- plus all accrued interest due at the time of payment to the requestor within 20 days of receipt of this Order.

This Decision and Order is hereby issued this 27th day of April 2005.

Medical Dispute Resolution Officer
Medical Review Division

DA/da

Enclosure: IRO decision

April 15, 2005

Texas Workers Compensation Commission
MS48
7551 Metro Center Drive, Suite 100
Austin, Texas 78744-1609

NOTICE OF INDEPENDENT REVIEW DECISION
Amended Letter 4/21/05

RE: MDR Tracking #: M5-05-1030-01
TWCC #:
Injured Employee:
Requestor: Rehab 2112
Respondent: Transcontinental Ins. Co.
MAXIMUS Case #:

MAXIMUS has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The MAXIMUS IRO Certificate Number is 5348. Texas Worker's Compensation Commission (TWCC) Rule §133.308 allows for a claimant or provider to request an independent review of a Carrier's adverse medical necessity determination. TWCC assigned the above-reference case to MAXIMUS for independent review in accordance with this Rule.

MAXIMUS has performed an independent review of the proposed care to determine whether or not the adverse determination was appropriate. Relevant medical records, documentation provided by the parties referenced above and other documentation and written information submitted regarding this appeal was reviewed during the performance of this independent review.

This case was reviewed by a practicing chiropractor on the MAXIMUS external review panel who is familiar with the with the condition and treatment options at issue in this appeal. The reviewer has met the requirements for the ADL of TWCC or has been approved as an exception to the ADL requirement. The MAXIMUS chiropractor reviewer signed a statement certifying that no known conflicts of interest exist between this chiropractor and any of the treating physicians or providers or any of the physicians or providers who reviewed this case for a determination prior to the referral to MAXIMUS for independent review. In addition, the MAXIMUS chiropractor reviewer certified that the review was performed without bias for or against any party in this case.

Clinical History

This case concerns a male who sustained a work related injury on ___. The patient reported that while at work he injured his right knee when he fell. On 12/7/02 the patient underwent an MRI of the right knee that revealed joint effusion and prepatellar edema, no evidence of a meniscal tear, a bone contusion with marrow edema along the medial margin of the medial femoral condyle and minimal changes of chondromalacia patellae. On 7/23/03 the patient underwent a thermal shrinkage right anterior cruciate ligament, partial medial meniscectomy right knee, and insertion of a PCA pump for postoperative analgesia through a

separate superlateral incisional portal for the diagnoses of intrasubstance tear right anterior cruciate ligament, medial meniscal tear right knee, and chondral fracture stellate-right patella. Postoperatively treatment for this patient's condition had included a work hardening program. An FCE performed from 1/14/04 – 1/16/04 indicated that the patient would be released back to work without restrictions.

Requested Services

Work hardening and work hardening each additional hour and functional capacity exam from 12/1/03 through 1/16/04.

Documents and/or information used by the reviewer to reach a decision:

Documents Submitted by Requestor:
None

Documents Submitted by Respondent:
1. MRI report 12/7/02
2. Final FCE report 1/14/04 – 1/16/04
3. WC/WH Program Daily Notes 9/19/03 - 1/16/04
4. Daily Therapy Notes 8/7/03 – 9/15/03
5. Work Hardening Notes 9/30/03 - 1/20/04
6. Operative Note 7/28/03

Decision

The Carrier's denial of authorization for the requested services is partially overturned.

Rationale/Basis for Decision

The MAXIMUS chiropractor reviewer noted that this case concerns a male who sustained a work related injury on ___. The MAXIMUS chiropractor reviewer indicated the patient had surgery for chronic pain on 7/28/03. The MAXIMUS chiropractor reviewer explained that the surgeons found no major problems. The MAXIMUS chiropractor reviewer noted that post operative therapy began, and he started a work hardening program on 9/22/03. The MAXIMUS chiropractor reviewer indicated that 15 visits of work hardening are enough for some improvement to be shown. The MAXIMUS chiropractor reviewer explained that if there were objective and subjective improvement, then further care would be indicated. The MAXIMUS chiropractor reviewer also explained that this patient showed no sign of improvement from 9/22/03-12/3/03. The MAXIMUS chiropractor reviewer indicated that this patient is non-compliant who missed visits almost as often as he went for care. The MAXIMUS chiropractor reviewer indicated that he was allowed to return to work with no restrictions based on time and not based on his care either surgically or conservatively. The MAXIMUS chiropractor reviewer noted that these services did not improve his pain or return him to work any sooner The MAXIMUS chiropractor reviewer also indicated that he has been through a large amount of conservative care for this condition without gaining much benefit. (TWCC guidelines, Mercy guidelines).

Therefore, the MAXIMUS chiropractor reviewer concluded that work hardening and work hardening each additional hour from 12/1/03-12/3/03 was medically necessary treatment for the patient's condition. The MAXIMUS chiropractor reviewer also concluded that work hardening, work hardening each additional hour and functional capacity exam from 12/4/03-1/16/04 was not medically necessary for treatment of the patient's condition.

Sincerely,
MAXIMUS

Elizabeth McDonald
State Appeals Department